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LEADING ARTICLES

THE DAWN AND DEVELOPMENT OF UROLOGY.*

BRANSFORD LEWIS, M. D.

ST. LOUIS.

WHILE urology has, for years back, numbered among its exponents men of individual brilliancy and bold originality, there has been, until comparatively recently, no systematized development of this as a well-defined or accredited department of the healing art, but it has rather been absorbed and diffused into the older subjects of general surgery and the practice of medicine. Even what individuality it may have possessed was not always of a desirable sort. It was often made to bear the obliquy of associations and associates far from respectable. Certain so-called "specialists" attached to its ranks were habitually dubbed by names more forcible than elegant.

It is on that account, as well as for their pre-eminent scientific ability, that a great meed of praise is due the fathers of urology in the days gone by. They were not abashed by these uninviting conditions; and, pioneer-like, they fought their way through the untrodden and often discredited paths of urology. Although their deductions may not always have been logical nor their teachings correct, they blazed a trail to the lasting advantage of those who followed in the same quest.

They had no such conditions for their encouragement and assistance as we have now. They had no such instrumental equipment as is within our reach at the present day; and no such clean-cut technique for its use, all formulated and served to us by our generous confreres. Diagnosis and therapy of urinary affections were not then reduced to the satisfactory degree of precision and accuracy now prevailing. Yet they investigated and practiced and wrote and enunciated precepts that challenge our unstinted admiration for their wisdom and intelligence.

Of the old countries, England, France and Germany have been most prolific in producing ardent students and practitioners of urology.

Who of our student-family but is familiar with the great work of Henry Thompson, later dubbed a Sir Knight, in recognition of his eminence in his chosen work? Who but has followed his well-marshalled arguments and logical deductions on the diseases of the urinary organs; his tremendous labor relating to vesical calculus, accomplished at a time when to "cut for stone" was a matter of no inconsiderable moment; the extent of which is evidenced in the collection of over a thousand urinary calculi and foreign bodies now in the keeping of the Royal College of Surgeons in London? We must not fail to appreciate, too, the helping hand this same patriarch of urology gave to the dawn of reason in prostatic therapy; to the transition from helpless and hopeless incompetency to the present condition of masterly ability in that line; in which, by judicious and well executed surgical measures, the days of torment and the nights of ceaseless vigil of the aged sufferer are replaced by peace and repose; in which the hunted look gives way to the smile of content not easily erased, in testimony of his reclamation to the well-earned enjoyment of his declining days, rather than a never-ending vibration between bed and closet in futile endeavor to obtain relief.

Sir Henry Thompson rendered a further valuable service by formulating an intelligent plan of investigation of genito-urinary cases, teaching that questions and physical exam-

*Presidential address delivered to the American Urological Association, at its sixth annual meeting, Atlantic City, June 3, 4, 1907.

ination should follow certain prescribed plans, which he outlined and adhered to. Such methodic plans, amplified and made to comport with modern armamentarium and technique, are now made use of by every conscientious practitioner of this line of work. They form a part of the advanced work of today, eliminating the haphazard of diagnostic research and promoting thoroughness, completeness and certainty of results.

The British Empire has been generous in contributing leaders in urological work. David Newman, of Glasgow, is renowned for his studious and authoritative contributions on renal surgery; and he has had worthy company in such men as Knowsley, Thornton and Henry Morris, whose writings are familiar to all who study the surgery of the kidneys. In the same category is Reginald Harrison, who insisted on the necessity of external, in connection with internal urethrotomy, from the standpoint of safety with respect to sepsis, hemorrhage, and reliability; whose studies in the etiology of prostatic hypertrophy have gone at least as far as those of others in solving this mooted question; that is, they leave it still "sub judice."

Harrison was early an advocate of surgical interference in renal congestion and inflammation, reporting the good effects of nephrotomy in connection with those conditions. He has been a devoted scholar of urology and his name will ever shine in the history of this branch of science.

Inseparably connected with the work of our own countryman, Belfield, is the name of McGill, of Leeds, England, in the subject of prostatectomy, since these two gentlemen were contemporary in the development and advocacy of suprapubic removal of the prostate for obstructive hypertrophy, in 1885. The value of the encouragement given this work by these gentlemen can hardly be overestimated.

One cannot leave off mentioning the shining urological lights of England without a desire to place one of her most illustrious examples, Hurry Fenwick, in the position to which his diligence and originality entitle him. He has been illuminating, as well as elevating, the stage of cystoscopy in England by his many years' work in that line and by the extremely valuable lessons to which his observations have led.

In addition to these, of the more recent period, England has given other urologists whose name and fame are familiar to all acquainted with medical history; such as, Sir Benjamin Bell, whose animated discussions with John Hunter on the subject of the relationship of gonorrhea and syphilis form interesting pages of the eighteenth century's history. Dickinson illumined the subject of nephritis in a masterly manner; and the charming literary style of Fothergill made his writings on diseases of the kidneys as fascinating as a novel.

France began early to contribute favorite sons to urological work. From 1830 to 1860 Civiale wrote instructive essays, embracing the history and practice of lithotrity, and the various means for treating calculus; urethrotomy for stricture; and finally, presented, in 1858, his Traité Pratique, des Maladies des Organes Génito-Urinaires, in three volumes, which discussed a wide range of urological subjects, quotation from which are to be found in all modern writings. While in London some years ago, I was fortunate enough to find in one of the old secondhand book stores of the Strand a set of these volumes, that, as indicated by the signed inscription of the author, had been presented by Civiale to Curling, the English author of a valued treatise on Diseases of the Testicles, 1848.

As Paris is to France, so is Felix Guyon to French urology. He "is the State," in that respect. His charming lectures and writings have lured many of us to pursue the devious channels of the French language if for no other purpose than to cull their enjoyment at first hand without the dilution of translation.

The urological clinic organized and conducted under the auspices of Professor Guyon, at l'Hospital Necker, in Paris, is an evidence of the masterly ability of its distinguished patron—one is almost tempted to say, patron-saint—and is probably not surpassed by any similar clinic extant.

His work is not confined to his own personal efforts. Under his inspiration his corps of assistants carry out the details of experimental or original work assigned to them, with the result of manifolding many times the genius of the distinguished savant, and enlarging his usefulness accordingly.

Other French names of distinction in urology are Albarran, Boisseau du Rocher, Pousson, Janet, Segond, Desnos, Halle, Jamin, and Delefosse; the last named especially for conducting what may be conceded as the best urological journal in circulation; the former for their assiduous devotion to the work embraced under this term.

If we view with admiration the accomplishments in urology in the Fatherland, including Austria, by such of their illustrious sons as Ultzman, who studied and elucidated the subject of neuroses of the urinary organs; Dittel, who wrote and operated well on surgical affections of the genito-urinary organs; Gruenfeld, who so materially advanced the

position of urethroscopy; Oberlaender, who promoted urethral pathology and therapy, and has made valuable contributions to our literature; Casper, who in addition to his cystoscopic work has studied the functionating power of the kidneys in relation to contemplated surgical measures; Gustav Simon, who first performed nephrectomy; Hahn, who demonstrated the feasibility and value of nephrorrhaphy; Israel and his formidable array of renal operations, recounted in his elaborate treatise on that subject; Freudenberg, who popularized the Bottini operation; von Zeissl, Kollman, Finger, Wossidlo, Frank, and Lewin; if we admire the accomplishments of these and many others that might be mentioned, how shall I adequately express the esteem in which the father of modern cystoscopy, Max Nitze, is held? The one who did more than any other to pave the way to precision in urological diagnosis and therapy as they exist today? If there has been one reason to explain the substantial progress along broad and scientific lines that has been made by this department of medicine in late years, the cystoscope is that reason. It has transferred the study of urinary diseases from an inexact, intangible, shifting basis to one of definite and established proportions. Together with ureter catheterization, the cystoscope has been the means of bringing within definite diagnostic reach all of the upper urinary tract—the bladder, the ureters and kidneys. Through this instrument, the world is ours, now, for the taking. A world of diseases and disorders is now placed lucidly before us—conditions that have hitherto been inaccessible and remote, or even unrecognizable. This field has heretofore been noted as one of speculation and argumentation, a diagnostic shuttle cock, dancing from point to point in accordance with the strength or weakness of theoretical contention. It was the mind of Nitze that materialized to practical use the idea of direct inspection of the bladder; his hand guided the growth of this wonderful instrument from its infancy to its maturity; from the cumbersome and dimly-lighted mechanism of the early days to the graceful and effective instrument of the twentieth century; and, fortunately, he lived to see the fruition of his hopes, the world-wide recognition of his instrument as a blessing to humanity, and its use in all civilized countries.

If I have reserved the mention of urologists of our own country for the last, it is not because they are less esteemed than those of the older countries, or that their achievements have been less valued. On the contrary, one can hardly restrain his justifiable enthusiasm when he thinks of the record made in urology by his compatriots in the short period in which his country's history is condensed.

Beginning with the luminaries of former days, of those standing out most prominently may at once be recognized the name of Bigelow, of Boston, whose forcible writings and effective instruments compelled acknowledgement of the value and position of lithotrity for vesical calculus; and Fessenden Otis, who was both original and radical; whose bold declarations were maintained with a vigor that compelled conviction; and it was only the sober, second thought of his urological pupils that kept them from following him like children followed the Pied Piper of Hamlin. Notwithstanding the radical nature of the elder Otis's teachings, and the fact that they were subjected to much pruning and mollifying by his followers, his mission was well fulfilled in awakening the medical world to higher ambitions with respect to the relief of urethral stricture and other urinary affections. His mechanical genius was pre-eminent and served to maintain the reputation for mechanical ingenuity perennially held by the Yankee. Happily, it was inherited and even amplified by the younger Otis, one of our revered and bereaved members and also initial Vice-President of this association.

Van Buren ably lent his stamp to the urological literature of this country; and after his work was done, transferred the burden and the honor of his duties to the younger but equally stable shoulders of Edward L. Keyes, who has for years been in the forefront of contention for progress that is well grounded, that is scientific, and worthy of being termed such. The contributions of this author have long been standard in American urological literature.

In venereology, Bumstead and Taylor held a commendable position. Gouley and his contribution to urethral surgery, both literary and in the form of valuable urethral instruments, must not be overlooked. Nor must we fail to acknowledge our debt to the scientific work of L. Bolton Bangs, who has taught us both the surgery and disorders of the genito-urinary system.

In former times the West and South have had able and worthy representatation in such men as Bryson, of St. Louis; Chismore, of San Francisco; Charles Briggs, of Nashville; James Dunn, of Minneapolis; Christian Fenger, of Chicago; Hunter McGuire, of Richmond; Ed. Palmer, of Louisville—whatever may be said of the representation of these parts of the country at the present time.

However, when we recall the names and associated accomplishments of Wishard, Belfield, Byron Robinson, Lydston, Goodfellow, Senn, Schmidt, Elliot, MacGowan, Kreissl, Rilus Eastman, Kolisher, Glenn, Whiteside, and a host of other present day laborers in this field, it may be conceded as true that these portions of the country are not altogether lacking in some worthy representation by the living.

Contemporaneous with them and, no doubt, often in competition with them are the wise men of the East of the present time, who while laboring in the field of urology to the lasting benefit of their profession, have been winning renown for themselves and a vast deal of credit for their country. Time and space are too limited for me here to mention all of their names, or recount their glorious deeds. Besides, it is presumed that they are present and can arise and speak for themselves.

Suffice to say, that their names, though legion, are as familiar as household words to us out West; that their work is watched with the same interest, solicitous, but not jealous, that is bestowed on the efforts of one member of a family by the others, and our delight in their success and attainments is not less than can be their own. In the realms of science there is no East, no West, no North, no South; we are brethren in a common cause; and that cause today is urology.

ORGANIZED UROLOGY.

If so much of a gratifying nature has been accomplished along urological lines by detached and unorganized efforts, how much more may be expected of the future, with urologists organized into coherent bodies, prepared to take up the burden jointly, and lend each other the encouragement of helpful suggestion, friendly criticism and healthy competition such as we find in this association? Such union of efforts and interests in this, our chosen field, have been in course of accomplishment for a number of years. The French Urological Association was formed in 1896, and has been active in its yearly meetings, bringing together the best of the French laborers in this field. This association furnished the inspiration for organizing our own urological Association.

The German Urological Association is also a vitalized fact and is holding annual meetings that bring out the customary thoroughgoing and conscientious work of the Teutons. And just recently a call has been issued for the convocation of the first Congress of the German Associaion of Urology at Vienna for next October.

In our own country the American Association of Genito-Urinary Surgeons has since its organization in 1886, made an enviable record, and won high esteem by its work in a field closely allied to the one in which our ambitions lie; although its limited membership and somewhat different trend of work mark a distinction between the aims and ambitions of the two Associations, a distinction that readily permits the continued existence of the two Associations as separate but harmonious bodies.

Our own sturdy young Asscciation came into existence five years ago (in 1902), the crystallization of the efforts of Dr. Guiteras and his friends, backed up by the membership ever to be honored by the designation "Founders," and to whom our grateful appreciation should ever be due.

This Association has a field of work that is unoccupied; that is inviting; that urges it to great deeds. It is built on broad, democratic lines. The merit system prevails and dominates its eligibility to membership and its councils. It invites independence of thought and freedom of speech—with scientific backing for such thought or speech. Precedent and conventionality are not named as guiding spirits of its policy, but *progress*, as sound and as substantial as that fleeting, ever-changing will o' the wisp may be, is, I take it, the keystone of its creed.

That the need of such an organization has been urgent and has been felt by urological workers; that its establishment has been hailed with pleasure and supported with enthusiasm; and that its future lies before, rather than behind it; its duty plainly evident, its ambition commendable, its care reassured—are all attested by its lusty growth in the few short years of its existence, by the character of its membership, and by its transactions already enacted. I presume there are few of its members who do not swell with pride, metaphorically, at the thought of being a member of this Association.

If these encomiums feebly express my esteem of membership in this body and the associations to which it leads, how shall I express my appreciation, even in a mild degree, of the honor you have conferred on me in making me your presiding officer for this session?

However unmerited, personally, was the selection; however, deficient I may prove in endeavoring to meet the requirements, I cannot but thank you sincerely, heartily and gratefully for your indulgence; and at the same time, for the sake of your young progeny, the Urological Association, to invoke your continued interest, your loyal support and your active participation in its work.

STRANGULATED HERNIA.

A. C. F. BROWN, M. D.

ST. LOUIS.

DEFINITION.—A condition induced in the sac by a constriction at its neck or in the sac itself, which completely occludes circulation entirely or partly, thereby exposing the contents of the constricted portion to liability of gangrene. The constriction may occur at the neck of the sac, entirely within the sac or entirely without the sac.

CASE I.—Patient, lady about 43 years of age, had been troubled with a hernia for several years. One evening she discovered her hernia had come down, and could not be returned. Taxis was tried without avail. An operation was suggested, providing the hernia could not be reduced under chloroform.

Report of the case referred to is continued by stating that vomiting and tympanitic distension were present, and there was some interference with the action of the bowels. Examination of the region revealed the presence of a small lump to the left of the groin about the size of the index finger. On palpation the characteristic sensation of hernia was detected. This sensation, although not easily described, is very distinctive and when once realized it is not easily mistaken, for there is something in the feel that enables us at once to recognize the character of the tumor. In this instance the swelling was rather firm to the touch, not, however, presenting the induration of an enlarged lymphatic. An exploratory incision was immediately resorted to, and this should always be done under the circumstances, laying open the overlying structure and exposing the knuckle. It was observed that tissue change had already taken place. A gangrenous intestine was found. Degeneration was quite advanced, and it was too late to return the protruded bowel. The latter, therefore, had to be cut away, and a fecal fistula established, but a fatal result was the necessity wherein if the operation had been made four days earlier the result would have been altogether different, and the probabilities are the patient's life might have been saved.

Another case which came under my observation was that of a woman between 45 and 50 years of age, who presented the usual symptoms of intestinal obstruction. Colicky pains radiating from the center of the abdomen or umbilical region with tympanites, constant vomiting of five days' duration progressively increasing in severity and great constitutional disturbance were present. The case was regarded as one of intestinal obstruction. On exposing the abdomen and examining the right inguinal region a nodule about the size of a walnut was discovered. The skin was thick and presented a brawny discoloration. There was evidence of early inflammation following infiltration, together with gaseous formation. When asked whether any previous trouble existed in the region it was ascertained that the woman had the tumor all her life, but paid no attention to it. An incision was carried through the infiltrated tissues and the coverings laid open, here again a gangrenous knuckle of intestine presented upon the opening, of which a gallon of thin yellowish offensive fecal matter exuded. The patient died of septic infection, as would have developed under similar conditions elsewhere. Some years ago, while visiting in a distant city a physician friend of mine was called upon by the authorities of the county to make an autopsy on the body of a woman whom it was thought had died from the inhalation of nitrous oxide, but which was not the case. The cause of death being intestinal obstruction. The case became one of medico-legal importance, and had been under the care of several most scholarly gentlemen. On going to the cemetery and opening the vault an examination of the body revealed the presence of a lump in the right femoral region, and upon making an incision a gangrenous gut was found. Now here are three cases in which a strangulated hernia was overlooked, the minds of the attendants having been occupied in some other condition less likely to exist. Therefore, let me add, always make thorough, careful examination of the inguinal and femor hernial regions, where there are present any of the indications mentioned, and where doubt exists make an exploratory incision to determine the true character of the tumor. If it was only a lymphatic enlargement no harm has been done. If it proves to be hernia, the exposure of it was the proper course to pursue. An omental protrusion may simulate quite closely lymphatic enlargement. The feel and resistance are about the same, and it is in these cases more especially that the exploratory incision becomes necessary. In one case referred to the inguinal tumor was supposed to be an enlarged lymphatic gland, and the attendant went so far as to ligate this enlarged lymphatic. Concluding to make exploration before proceeding otherwise, an incision was made and presenting there was found, not an enlarged lymphatic, but a hernial protrusion. The tumor was composed of omentum with an enveloping sac. The small knuckle of intestine was exposed and had to be slit before the constriction could be relieved, the cases in which it becomes necessary to open the

sac, and is usually of a more serious character; but this constriction must be relieved whether it be internal or external, although attempts should aways be made to return the protrusion before resorting to any cutting operation. In other words, taxis is to be employed and this consists of scientific manipulation effecting reduction by taking advantage of certain influences as regards position and structural relation. Pressure is to be applied, but considerable precaution is necessary, as it is better that it be too little than too much for the degree tolerated is very uncertain. The same to a greater or less extent is true of the time which taxis should be continued. There is no definite rule laid down. "Every case is a law unto itself."

The sensation imparted is a valuable guide and condition of the part or time during which strangulation existed are also to be taken into consideration. If undue attempts be employed rupture may be produced; extravasation and gangrene, which means death almost for a certainty.

Regarding the amount of force and how long the taxis should be continued no definite rule can be laid down. Pressure too great and applied for too long a time may ultimately cause a fatal result. The continuous attempts at reduction permits of prolongation of the constriction. Taxis properly conducted will often succeed, relaxation of tension is the important point, hence the flexion and moderated adduction or internal rotation of the thighs. In addition to this, slight pressure is to be made over the tumor, which is also moderately elevated to empty its contents. Anesthesia should always be induced. Taxis may then be continued for five, ten, fifteen minutes, according to circumstances. We are to use our own judgment in these cases, and it cannot be said absolutely how long this method is to be tried. In some instances taxis for fifteen minutes may be kept up with less danger than its continuance for five or ten minutes would amount to in other instances. If the pressure has been sufficient and the resistance not too great there will be a gradual diminution in the size of the tumor, or as occasionally happens, there will be sudden reduction, as indicated by the gurgling sound said to be so characteristic. Gravity is an important symptom in reduction when relaxation is secured by flexion and adduction of the thigh and the protruding knuckle elevated the weight of the intestine drags it into the abdominal cavity. To this movement moderate pressure is applied. It may not be necessary to induce anesthesia, the individual is conscious of what is going on, and in consequence may aid the surgeon in his efforts. But to relax this tension when strangulation is present the anesthetic is most satisfactory.

If uncertain as to its nature the effect of manipulation should first be observed. After failing in all reasonable attempts to reduce the hernia patients will not submit to an operation. Under these circumstances the effect of gravity is to be tried elevating the foot of the bed, and at the same time making cold applications. This method sometimes proves very satisfactory, and should be given a trial when the more certain radical procedure cannot be at once resorted to. Cold under such circumstances is preferable to heat, the latter producing dilatation of the vessels causes an increased inflow, and the walls becoming thicker in consequence of the increased amount of blood present. The cold applications act in two ways: First, lessening the amount poured in, and second, by inducing contraction causes the blood present to be expressed. In a few cases the ice cap will suffice, and the tendency to inflammation is to a great degree combatted.

In a case recently under my care the patient was ordered nothing to eat or drink for twenty-four hours, and that the ice cap should be constantly applied, in a few hours the hernia went back, the reduction occurring during the period of sleep. And why? Because the circulation became slowed down the peristaltic movements of the intestine, which are more or less of a continuous character then pulled the protruding portion in.

This vermicular motion commences above, and gradually progresses downward, traversing the whole intestinal tract, and being therefore propagated to the protruding portion. Thus the natural tendency is for the latter to be pulled in.

The hypodermic injection of morphine for the purpose of tranquilizing pain and suffering is usually recommended, but we are not advised to employ it as a rule, for it may be a source of deception, benumbing the sensibility so that no expression of distress is offered, even though a grave condition of affairs be present. Therefore, it is better to refrain from the use of morphine in these cases.

Rectal injections, using simply soap and water, is often of service; with the emptying of the bowel the intestine may become dragged in and returned to the abdominal cavity, but such injections will often fail to effect any good other than emptying the bowel.

If reduction cannot be effected in a reasonable length of time by the ordinary means, more radical measures should be resorted to. Delays are dangerous.

Now, the operation for strangulated hernia is one which is looked upon with a great deal

of fear, being said to require skill and care and thorough knowledge of the regional anatomy. But what operation does not? These are requisite to every operation, and there is none without a certain amount of danger.

It is true, however, that in this instance unusual interest is attached to the operation, and the ordinary physician should be able to perform it. The dangers and precautions to be observed vary according as the intestine is or is not to be opened, the incision through the external parts of course require judgment. The indications for the operation are obvious. Contraindications to the second step are afforded by evidence of breaking down of the intestine along the external tract, this condition necessitating removal instead of return to the abdominal cavity.

The anatomy of the coverings is put down as being of great importance, several layers are enumerated, and it is well to know them, but the surgical coverings are not many, practically regarded as consisting of one, although six, twelve or twenty layers may be made if one chooses. Overlying skin is counted as number one; superficial fascia, two. The next layers depend upon whether the hernia is inguinal or femoral

In the inguinal variety we have the external oblique aponeurosis. The intercolumnar and cremasteric fascia, the skin and superficial fascia have nothing to do with the constriction. The coverings are not separated into distinct compartments or layers, and it does not make any difference whether we make one incision or a half dozen

Look for the external oblique aponeurosis, this can be recognized by its bright shining fibres, as in dissecting, running in the direction indicated by the name and leading to the external abdominal ring. Having exposed this get the finger under or introduce the groove director, and with the edge or the finger nail the constricting fibres may be torn or nicked sufficient to allow the hernia to go back. The latter being prevented by the resistance of the tissues it becomes necessary to divide with a knife the superior pillars of the ring at the seat of constriction. The hernia knife devised by Cooper is used for this purpose. Having a blunt probed pointed blade, this is passed or guided by the finger and cutting the fibres of tendons at the superior pillars of the ring over the neck of the tumor. It is not so much by cutting as it is by tearing that the constriction is relieved. The finger is carried in after simply nicking with the knife, and then the resistance may be overcome to a degree sufficient to permit the return of the intestine. The hernia is to be drawn down to detach the neck from the groove formed by the constriction it then suddenly recedes into the abdomen, going back with or without the gurgle. But often it is not necessary to open the sac the constriction being external to it. This form of operation is that of Petet. It is a very old one, being over 150 years old, and is today generally employed. It has the advantage of not involving the peritoneum. The patient can walk on the ninth day. Union occurs by first intention and the patient has practically recovered by the fourth or fifth day.

The probe pointed knife is much the safest in these cases when cutting is necessary, for as soon as the knuckle of intestine is freed it will return to the abdominal cavity. But under certain circumstances it may not be advisable to allow a return after the constriction has existed, if for a certain length of time the nutrition of the part has been interfered with, it is exceedingly dangerous to return it to the abdominal cavity. Therefore examine closely the protruding bowel when there is a history of the patient having been prostrated a number of hours.

The continuous pressure and nipping of the gut for a considerable time leads to inflammatory change, the circulation is seriously interfered with and ulceration is liable to follow. When on examining the intestine small whitish points are found along the surface where the depression exists, or the presence of small herpetic vesicles containing effused serum which escape when the vesicles are broken, be exceedingly careful, and do not under any circumstances return that bowel to the abdominal cavity. Ulceration is in progress and degenerative changes are going on, and it would be the height of folly to return the intestine when this ulcerated groove exists. There is loss of vitality and gangrene, the grooves of decomposition are present, and the septic inflammation would be followed by perforative peritonitis, and death in twenty-four hours. There is a possibility of restitution and return to the normal, but when advanced the probabilities are that ulceration will continue, causing perforation. Therefore, look out for danger in these cases. It should be understood before putting the patient under the anesthetic, that if taxis does not succeed the cutting operation is to be resorted to.

The first object upon opening the overlying structures is to ascertain the condition of the bowel, the constriction is then to be relieved and the hernial sac excised or returned, as the case may be.

The constriction will usually be at the neck of the tumor at its junction with the body.

When it is necessary to open the hernial sac for relief of the constriction accurate closure must be made if it is to be returned. The thin serous covering of the tumor is easily recognized, but usually the aponeurosis of the external oblique will be the cause of narrowing in the canal. As a rule the finger can be introduced under the fibres along the tumor and the constriction divided. Without the use of the knife it may be difficult to liberate the intestine.

Hypodermic puncture of the tumor when it is tense from accumulation of fluid or gas may facilitate reduction. In the vast majority of cases the trouble is not in the sac of the hernia itself, but in the tissues external to it. Evidence of morbid changes in the former will be found in the escape of yellowish discolored, more or less offensive fluid, when the sac is opened. Fluid of this character may be found at the bottom, and hence the importance of a free incision opening the full length. The sac is not always thick, and owing to the thinness it may be difficult to tell when it is really opened. The yellowish patch upon its surface is most indicative. A serious disadvantage to this long incision is the liability or danger of cutting the exposed intestine, and it is not desirable to have this occur when it is unnecessary. An incision may be made just long enough for the introduction of the little finger. When it reaches the seat of the constriction the knife may be carried in flatwise, then turning up, saw through the edge, nicking it sufficiently to cause it to yield under pressure of the finger, which is carried on upward, tearing through the tissue, while the knife is withdrawn. Having done this pull the intestine out and examine it carefully. If there is evidence of injury or tissue changes do not put that gut back; this should be made a positive rule for perforative peritonitis is sure to follow. Much safer is it to excise the strangulated loop and establish an artificial anus.

In the majority of instances where the bowel has been subjected to pressure for a considerable length of time the normal appearance becomes lost and a black color is assumed, the discoloration may be very marked, and an enormous quantity of fluid may be put up. At other times where relief of the constriction has been immediate no such changes has been suffered, as to whether the bowel shall be returned or not depends. Therefore, upon circumstances when clear and glistening in appearance it may be returned, but when dull and mottled studded over with dark spots or yellowish patches and presenting marked evidence of diminished vitality its return to the abdominal cavity would be followed by the most disastrous results. The dull muddy appearance and presence of small blebs or vesicles are indicative of putrefactive changes, and in this condition it would not be safe to return the bowel. The changes consequent upon continued strangulation offer a striking contrast to the appearance in health and the bowel in such condition can be easily recognized. If normal after relieving the constriction the fluid is pressed out the bowel is put back or fastened in the wound and recovery takes place, there being no extravasation and no peritonitis to complicate the operation.

If the omentum is damaged, throw a ligature around its base, making sure the knuckle of intestine is not included. The stump may be returned or left fastened in the wound. If not appearing as healthy omentum, occasionally it will be advisable to leave it anyhow for the purpose of blocking up the wound effecting a closure of the opening. The individual may or may not recover. In the more grave cases death has occurred in twelve, twenty-four or thirty-six hours. The fatal termination may be the result of septic absorption from the putrefactive area, or a septic peritoneal inflammation from direct extension of the morbid process. The general peritonitis does not develop so long as the constriction lasts, but with the entrance of the gangrenous knuckle of intestine into the abdominal cavity a general inflammation is lighted up and death speedily follows. Occasionally persistent strangulation causes death, this result being preceded by profound prostration and collapse. Relief of the constriction does not necessarily mean restoration of the physiological function, even though there be no inflammatory complication.

After the pressure has been taken off the gut sometimes remains paralyzed, and it is very important that this be borne in mind.

McGill University Medical Building. —It is planned to rebuild the medical building of McGill University, which was recently destroyed by fire, on a plot of ground immediately opposite the Royal Victoria Hospital. The ground is owned by Lord Strathcona, who bought it for the purpose of preventing residences being built opposite the hospital, and is believed to be willing to place it at the disposal of McGill. The laboratory, which practically escaped the flames, will remain where it is, but the plot on which the medical building proper stood will be cleared and left for the general beautification of the gounds.

The Medical Society of City Hospital Alumni

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OFFICIAL TRANSACTIONS.

A CASE OF EXTRA-DURAL ABSCESS.*

SELDEN SPENCER, M. D.

ST. LOUIS.

At the time of my first visit, February 20, 1907, I found the patient, a girl of seven years, suffering from a severe attack of acute suppurative otitis media. The case was typical of the class complicating influenza. The drum membrane had ruptured and there was a profuse bloody purulent discharge. Deafness was even more marked than is usual in ordinary cases of acute purulent otitis media and, despite the perforation, the pain was severe. The temperature was 102.

The ear was irrigated with a warm boric acid solution, and the nasal cavity cleansed with an alkaline wash. After the external ear had been cleansed and dried, the middle ear was cleared of discharge by mild inflation. The canal was again mopped out and thoroughly dried and a gauze drain placed loosely down to the opening in the drum membrane, seen in the superior quadrant. Calomel in one-tenth doses, to be followed in the morning by a saline, was prescribed.

On the following day the child's temperature was found to be reduced and her condition somewhat better; however, improvement was not as marked as usually found in ordinary acute purulent otitis media after good, free drainage is established. The discharge continuing profuse, the gauze drain was discontinued. (The mother had been advised to remove the drain as soon as it should become saturated, for in this way was obviated the sole objection to the use of the drain where the discharge is not too profuse—in such case its use is neither advisable nor desirable.)

The child improved slowly, but the discharge continued as before. After a period of about ten days, redness and swelling began to appear over the mastoid region, and I advised that the child be immediately placed in a hospital, and on the following day she was taken to the Martha Parsons Hospital. The pain behind the ear was now quite severe and marked fluctuation was present. Hoping that the drainage of the post-auricular abscess would relieve the trouble, a Wilde's incision was made on March 5th. Quite a quantity of pus was obtained, and as the bone was found in good condition, further operative procedure was postponed.

After the foregoing operation the pain subsided and the general condition and the appetite were greatly improved. A striking characteristic of this case was the temperature, which, after the first few days, continued almost normal. For several days after the operation the patient seemed bright and happy; but on March 12th, complained of headache and refused her food. Later in the day she vomited, and the nurse reported that on the preceding day patient had been allowed too much ice cream. The vomiting was not cerebral in character and, at the time, there were no cerebral symptoms present. A purgative was given, but on the following day the headache was still present and there was no appetite. On the afternoon of March 12th the tempearture was 100; the pulse 120; the respiration 26; but, on the following morning, the temperature was normal and remained normal. About this time the patient began to show signs of drowsiness and passed into a stupor, and protested whenever aroused. She became very irritable, and when awakened would whine and beg to be let alone. Headache was marked and symptoms of meningeal irritation began to appear.) The neck was rigid; König's sign was present; respiration became irregular and shallow, though the pulse at this time was good; there was no aphasia and but little constipation. Drs. B. W. Moore and Tuttle, members of the hospital staff, saw the case in consultation. Dr. Leudde, who examined the eyes, reports the following condition: The most marked symptom was a conjugate deviation of eyes toward right. This symptom is regarded as grave, indicating fatal ending. Eyes looking toward right, unaccompanied with evidence of paralysis of any ocular muscles, made it certain that there was some irritating lesion of the left cortex.

* Read at the meeting of May 16th, 1907.

The pupils were dilated and responded slowly, probably due to sympathetic irritation; fundus, normal; hypermetropia about 4d; visual tests, uncertain.

It was decided to perform without further delay the mastoid operation and craniotomy. On March 16th chloroform anesthesia was given and the regular mastoid operation begun, Dr. Simon assisting. On opening the cells a quantity of pus was found; the antrum was attained and the sinus and dura exposed The sinus being found in good condition, was not disturbed. The opening in the bone was extended with the rongeur forceps and chisel and a large quantity of pus was drained from an abscess located immediately above the sinus knee, about two ounces being removed during the entire operation. The wound was dressed with a rubber tube drain leading to the depth of the abscess. The general condition of the patient greatly improved, and about four days after the operation, Dr. Luedde again examined the eyes. He found the patient up and playing about and reports that there was no deviation, singly or together; roughly, V.=.6 with Landolt's optotypes; without correction of the ametropia; pupils responded normally in every way.

Everything continued favorable with temperature normal and pulse and respiration good until about ten days after the operation, when meningeal symptoms again began to appear. The patient became drowsy and was with difficulty aroused. Dr. Luedde again examined the eyes and reports as follows: Return of symptoms as found in the first examination, but much less marked; the only indication of conjugate deviation, and occasional turning of both eyes to the right. The discharge was scant, so the patient was again put under anesthetic and the wound curetted. The rubber tube drain was replaced by the gauze drain. On the next day the condition was not much improved, but on the day following the discharge was more profuse and all alarming symptoms had disappeared. From this time the patient made an uneventful recovery, and just four weeks after the first operation and two weeks after the curettage above described, was discharged from the hospital as cured, the middle ear being dry and the posterior opening entirely closed.

The most interesting feature of the case was the conjugate deviation which, as a rule, is considered a serious, if not a fatal, symptom. The temperature was almost continuously normal; but this is not a particularly peculiar symptom, as in these cases the temperature does not usually rise, though it may do so. The pulse was rapid at the time of the operation, and so continued until the date of the relapse described, after which it remained slow for several days. On this morning the child called at my office. She was in good health and her hearing practically normal.

DISCUSSION.

Dr. Sauer asked why the Wilde incision was made. Also, how long afterwards did the post-auricular abscess develop?

Dr. Spencer.—About ten days.

Dr. Sauer then said, The majority of mastoid operators have given up the Wilde incision, because it is entirely insufficient to reach the condition. A majority of these swellings are due to direct infection of the mastoid. Occasionally they start from a furuncle in the canal. It is always wise to cut down on the mastoid. I believe that this abscess could have been avoided if the mastoid had been opened up. Where was the sinus leading into the cranium?

Dr. Simon.—I have made the Wilde incision several times, and quite frequently patients have gotten along without any chiselling. In all these conditions of intra-cranial complications following otitis media it is very difficult to make a differential diagnosis. In this particular case we excluded diffuse purulent meningitis. Another thing that is peculiar is conjugate deviation. I think that focal symptoms as a rule are absent in extradural abscess. I think that one of the mistakes that are usually made is that if intracranial symptoms are present, we should not hesitate to open up the skull. These cases get along nicely if there is plenty of drainage.

Dr. Luedde.—This deviation can hardly be taken as a focal symptom. It can come with any lesion of the left cortex. Anything that will start associated movements of the eyes, whether it starts from the auricular centers can act as an imperative stimulus for conjugate deviation. Of course, it indicated an irritation of the cortex and made it likely that something could be found on opening up the skull. Weiselberg has said that the symptom has been regarded as a fatal one. I saw one other case where the result was fatal.

Dr. Clarence Loeb.—As far as the Wilde incision is concerned I think Dr. Sauer is correct in stating that the majority of otologists have given it up. At the same time, Dr. Simon is right in his statement. It depends upon whether the cells are involved. If the cells are broken down, the Wilde incision is insufficient. If the cells are intact, if you have a wide incision in the drum, then the

antrum may evacuate itself through the external auditory meatus. In every case of mastoid abscess, we do not have to do a mastoid operation. It is simply a question of whether the antrum alone is involved or whether the cells are affected. There is one point in the doctor's paper with which I do not agree. About a year ago the French otologists took up the question of what was the best way of treating otitis media and they decided to insert drains in the external auditory canal, that is, where the drains can be frequently renewed. If the patient is in the hands of the relatives, then I think a drain placed in the auditory canal, to be renewed by unskilled hands, is detrimental.

Dr. A. E. Meisenbach.—This question is a very interesting one. The focalizing symptom as it was called, was made the subject of a discussion in a series of cases by Weiselberg. His point was to determine where the lesion was situated, and the conclusion was, in the posterior portion of the frontal convolution. Previous to this statement, the temporal region was considered to have much to do with this condition. It was Wieselsberg's conclusion that it was due to irritation of the subcortical fibers. In this connection it is pertinent to mention a case of brain tumor where the eyes were rolling from side to side. The right eye did not exercise the same excursions as the left. In that case, I made out a swelling of the head of the optic nerve. Post-mortem findings revealed a tumor in the angular gyrus.

Dr. Simon.—I did not mean to say that conjugate deviation is a focal symptom in the strict sense of the word.

Dr. Kirchner.—I would like to speak on one point. At the city hospital we meet with cases of middle ear trouble, followed by abscess, first extra-dural and then intra-dural. These cases should be operated on early. In certain cases the clinician has advised against operation, and the patient has submitted to operation only after focal symptoms had mainfest themselves, paralysis of the hand or leg, indicating intracranial abscess. Large openings would be made and a large abscess found, but the patients died within a short time, owing to the delay in operative interference. Another thing that I have noticed is that we may have an extra-dural condition without much affection of the mastoid.

Dr. Sauer.—Mr. President, you did not mention whether the mastoid would be affected. Another point in regard to the Wilde incision is that it is but a little better than the leech or the ice-cap. When the condition is due to suppuration in the middle ear cavity and it travels into the mastoid cells, I do not see how the Wilde incision can do any good. If you take enough trouble to make a Wilde incision you might as well open the mastoid and do the work thoroughly.

Dr. Spencer.—I take issue with what Dr. Sauer has said. This incision opened a post-auricular abscess. I do not believe any more than does Dr. Sauer that a Wilde incision is sufficient when you are sure that there is a mastoiditis present. In regard to Dr. Loeb's statements regarding drainage, I do not think that a gauze drain should be put into the ear. In this particular case that I am reporting, the mother of the child had been a nurse in the hospital. I told her to remove the drain whenever it became saturated.

PAPILLOMA OF THE CARUNCLE WITH REPORT OF A CASE.

CLARENCE LOEB, A. M., M. D.

ST. LOUIS,

Assistant in Ophthalmology, St. Louis University.

ALTHOUGH the individual structures of the eye have been the object of very extensive investigation, the literature dealing with the caruncle and its diseases is very meager. The subject is dismissed in a few words in the smaller text-books, and even in the larger one, such as those of Fuchs (1) and De-Schweinitz (2), it is discussed in a paragraph or two of general remarks. This paucity of information is due to two factors. In the first place, the caruncle is very rarely the sole seat of the disease. In the second place, the structure is a relatively unimportant one, and is of interest only to those making a special study of the eye. When the caruncle is pathologically affected, the process is usually part of one involving the entire conjunctival sac, and the treatment is the same as that directed against the latter condition. The unimportance of the structure is emphasized by the general ignorance as to its anatomy and physiology. Even its exact relation to the other parts of the eye is not settled. In the Catalogue of the Surgeon-General's Library, references to the caruncle are indexed as a sub-head to the lachrymal organs, while in most of the ophthalmic text-books, it is discussed in connection with the conjunctiva.

Under the circumstances, it would be advantageous to review briefly the anatomy and physiology of the caruncle, before proceeding to the main subject of this paper.

The caruncle is a reddish projecting mass lying in the inner canthus of the eye, but in-

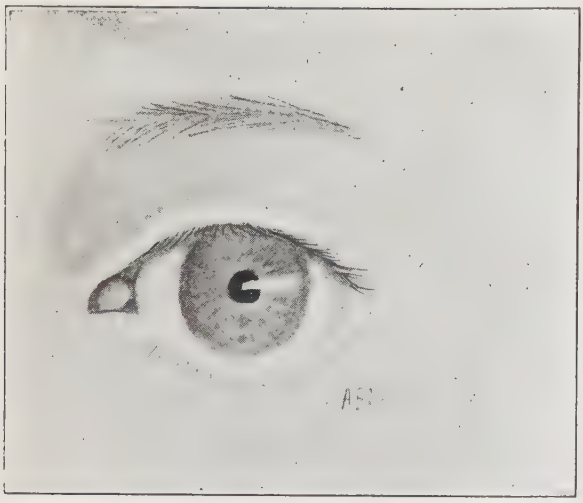

Fig. 1. Papilloma of the Caruncle (Dr. Loeb).

ternal to the niveau of the lids. It has a more or less conical shape, with the apex outward, and is about the size of a grain of wheat. The name is derived from the Latin caruncula, the diminutive of caro, meaning flesh. Microscopically, however, it is found to consist of dermal tissue covered with epidermis, from the surface of which project fine hairs. These are sometimes so long that they cause irritation of the bulbus oculi. The caruncle possesses both sebaceous and sudoriparous glands. There are present, also, some glands of Krause, which resemble lachrymal glands.

As to its physiology, very little is known. Possibly the secretions of these glands aid in moistening the eye, which would furnish a certain amount of justification for classing the caruncle with the lachrymal organs. It has been suggested, also, that the caruncle with the plica semilunaris act as a sort of a dam to prevent the too rapid outflow of the tears from the conjunctival sac (7). As stated before, the caruncle may take part in the diseases of the conjunctival sac. It may, however, be the sole seat of the pathologic process, which is then called encanthis. This takes the form of tumors, which may be either malignant or benign. The most usual form of the malignant type is the melanosarcoma. Other varieties are sarcoma, angio-sarcoma and carcinoma. The benign forms are usually polypus or papilloma. The term "usually," however, is only relative, for a search through such reference works as the Catalogue of the Surgeon-General's Library (3), the Index Medicus (4), Nagel's Jahresbericht (5) and the Ophthalmic Year Book (6) reveals reports of only thirteen cases, one of which is doubtful. Though there is the possibility that some cases have been overlooked, the condition is at any rate seen to be very rare, justifying the report of the following case:

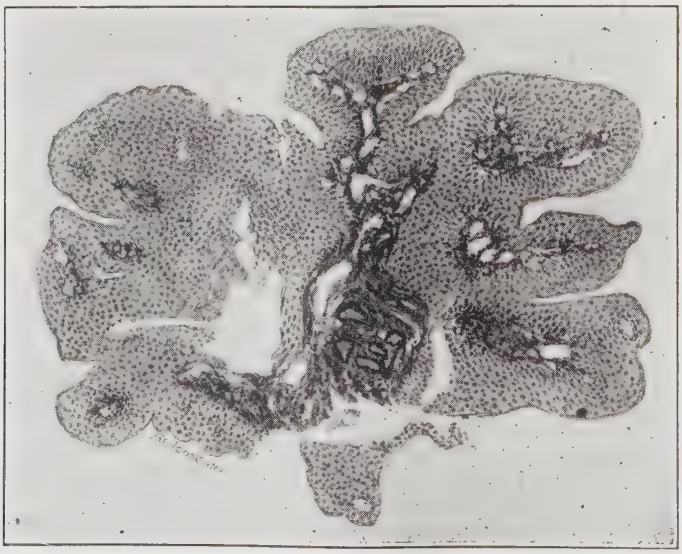

Fig. 2. Papilloma of the Caruncle (Dr. Loeb).

Mrs. G. H. R., age 27, presented herself on February 5th, 1907., complaining of an unpleasant sensation in the left eye, described by her as a "feeling that there was something in it" which she had noticed for about two weeks. It was most pronounced in the inner corner of her eye, and had caused her to "pick" at it, without experiencing any relief.

Family History.—Patient stated that her maternal grandfather and great-grandfather had each become blind in the left eye—cause unknown, and that the left eye of her mother had become smaller and was losing sight without any apparent cause. The patient qualified the word smaller by explaining that the eye seem to be receding into the head. Naturally she was the more alarmed on her own account.

Examination of the left conjunctival sac showed that it was slightly more hyperemic than that of the other side. No foreign body in it or on the cornea. The media were all clear, and the fundus was normal. This was especially carefully examined on account of the unfavorable family history. The vision was $\frac{6}{6}$ for distance, 0.37 on the test card for near vision.

In the inner canthus of the left eye there is seen a small red mass, about the size of a radish seed, which springs from the caruncle and projects forward between the lids. A probe can be passed around it on all sides except posteriorly, where it is attached by a broad base to the whole of the caruncle. It is freely movable, except at the base. With a lens, the surface is seen to be uneven. When the eye is closed, the mass still projects through the palpebral fissure, but disappears when the eye is tightly closed.

A tumor of the caruncle, probably a papilloma, was diagnosed, and the patient was advised to have it removed, to which she consented. Under cocain anesthesia, the mass was grasped with a pair of forceps, pulled forward and outward, and cut away from the caruncle by means of a small pair of curved scissors. The base was then carefully and minutely cauterized with an electrocautery point, just below red heat. This is a very important part of the treatment, for unless all vestiges of the growth are destroyed, the tumor will return. After the cauterization, a little 10 per cent boric acid ointment was placed over the caruncle, and the eye was then tied up. On the following day, the caruncle was red and somewhat larger than that of the opposite side. On the second day it was still slightly red, and about the same size as that of the right side. On the third day, both caruncles were pale and of equal size. Since then she has reported several times for examination. The condition remains the same. The last time I saw her was May 14, 1907.

The mass removed was placed in formol, embedded in paraffin, and the sections were stained with hematoxylin-eosin, Van Gieson's and Mallory's stains. Even macroscopically, fine projections could be seen springing from the main mass, suggesting papilloma.

Microscopically, the tumor consists of a central stock of connective tissue and blood vessels covered with stratified squamous epithelium. The most external epithelium is thrown into numerous projections, eight in the specimen under the microscope, separated from each other by more or less deep grooves. Each papilla consists of several layers of stratified squamous epithelium clothing a central area of connective tissue and capillaries, which can be traced as continuations of the stock of the main mass. One of the papillae has been torn away in preparing the section, and can be seen at some distance from the main mass of the tumor. Its place is occupied by epithelial and connective tissue remnants. These findings confirm the tentative clinical diagnosis of papilloma of the caruncle.

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If a patient has had a nasal operation performed, especially if the accessory sinuses have been operated upon, severe frontal headache may mean thrombosis of the cavernous sinus, even if no fever be present.

THE Mutual Life Insurance Co. of New York and the Equitable have restored their examination fees to the old figure, $5. This action has resulted from the vigorous and determined protest made by the medical profession.

WANTED. — To exchange dispositions with some one: Who thinks summer preferable to winter. Who can keep sweet when the temperature is 100 in the shade. Who would rather hear a mosquito than a blizzard outside. Who rises during dog days refreshed and uniformally good natured. Who can eat sliced cucumbers and drink iced tea without misgivings.

MEDICAL SOCIETY OF THE MISSOURI VALLEY.—An attractive program of twenty-three papers has just been issued by the secretary for the meeting of this association, which will be held at Council Bluffs, Iowa, on September 5 and 6. The railroads having declared for a two-cent rate in this territory, those who attend this meeting will travel on the basis of one and a third fare for the round trip. A cordial invitation is extended to the medical profession. Headquarters at the Grand Hotel.

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Editorial Rooms, Suite 319-321 Century Building, St. Louis.

EDITORIAL

The Question of New Remedies Again.

WE have recently received from the A. M.A. a copy of resolutions which were adopted by the Council on Pharmacy and Chemistry at the Atlantic City meeting, which we have pleasure in reproducing:

Whereas, The Council on Pharamcy and Chemistry, after examining many hundreds of preparations, has officially announced its approval of a large number of such preparations; and

Whereas, We believe that the editors of many medical journals in this country, both official organs of State Associations and privately owned journals, are desirous of cooperating in the work of freeing the medical profession from the nostrum control; be it

Resolved, That this Association most earnestly requests all medical journals to refuse to aid in promoting the sale of preparations which have not been approved by the Council, by refusing space to such preparations; and be it further

Resolved, That we most earnestly request the moral and financial support of our members for those medical journals, whether privately owned or controlled by medical organizations, which disregard commercialism and stand firm for honest and right dealing, thus sustaining the Council in its greatest work for the medical profession.

We are only in the slightest at variance with the Council, and this touches the point of variance, our aim is no less for clean, practical, scientific medicine than is theirs. But we feel that the supervision of the Council as at present established would have cost the profession many of our most valuable remedies had it been continuously in force for the past twenty-five years. Therapeutic progress demands a considerable degree of freedom on the part of the profession in the matter of untried remedies, the physician is the court of first resort, and, in case of substantiated clinical effectiveness, the last. The Council may give us a clearer insight into the exact composition; it may hinder extravagant and impossible claims in exploitation; it is primarily opposed to frauds and can legitimately free the field of such. But with power comes a chance for abuse of power, and there is always a chance that arbitrary endeavor to control beyond what is really called for will develop; that medicines with real merit will be branded as frauds, journalists of high aims and honest motives who have dared to question, will feel the mailed hand. We have always believed that remedies without merit could not continue to live, simply because physicians must get results; we have witnessed the exit of a number which could not make good and we can see others who are marked for a speedy demise. But physicians must be privileged to make clinical trial of new remedies, the pharmacist-chemists constituting the Council may assist us to valuable information as to the exact ingredients, but they can not give us the information which can only be gained by clinical experience.

The campaign against nostrums has done much good, the profession has reason for profound gratitude to the Council for much that it has accomplished. The Association has yet some work to do in the way of purging the advertising pages of some of its State journals which continue the advertisements of some unapproved remedies. And we must confess to an inability to see why "anti-this" should be approved and "anti-that" be denied approval when the representative of the manufacturer of "anti-this" can find nothing better to say of its character than that it is just the same as "anti-that."

We aim at clean, practical, scientific medicine. Just as fast as we are convinced that remedies advertised in the FORTNIGHTLY are not therapeutically effective we will seek no renewals. But we claim for the profession the right to make its own acquaintance with new remedies and to establish the right to a claim of clinical effectiveness.

The Greek Invasion.

THE cosmopolitan character of our population leads to little comment being caused by the introduction of new elements. The countries of Western Europe have contributed materially in making the American of today and each of his strains is traced with a degree of pride. The later

coming of the peoples from Eastern Europe introduces elements which are not so easily assimilable and bring problems which are much more serious than any which the nation has before faced. The rapid coming of the Finlander and the Russian Jew is a notable feature of the present, but each of these readily accepts American conditions, the Finn soon loses himself becoming an American and adopting the English language, the Russian Jew adheres to his religion and, in cities, remains a foreigner through one generation, but in the country he speedily adopts our ways and is a desirable acquisition. A new element which is purely a matter of the past decade is Greek immigration. The early comers from Greece were fine specimens of manhood, an addition to any community. Latterly the importation leads one to infer that the immigration companies used the good material to create a welcome, and are since dumping on us a very inferior class of humanity. The "fair haired Greek" of classic literature seems to be in no way related to the Greek immigrant, who is a swarthy individual of stunted physique whose appearance forcibly suggests a combination of the Turk and Bulgarian. The Greek in America is not showing himself an especially desirable acquisition, as is demonstrated in the records of the police courts of any of the cities to which he has come in considerable quantities, he is easy prey for disease, and is also a creature of the free clinic. He is a victim of vices, such as usually overwhelm those unused to freedom such as exists in America. It has also been said of him that he an individual who is liable to carry a knife up his sleeve and a preference for the back as a point of entry when he attacks. Our principal interest in him is in his influence on health, and we must confess to a considerable amount of curiosity how a large number now resident of St. Louis ever succeed in passing the immigration inspection. It appears that there is an urgent demand for strict investigation of the health of seekers of freedom who claim Greek origin and the return of those who are undesirable.

Legal Protection Against Substitution.

THEORETICALLY no reputable druggist substitutes, he will tell you so. Accepting this as a fact, it is remarkable that the pharmacists of New York, both as individuals and in their organized bodies, have been so bitterly opposed to the enactment of a law which makes substitution in filling a physician's prescription a misdemeanor, punishable by fine and imprisonment. The bill passed both houses of the State assembly and has received the signature of Governor Hughes, the law becomes effective September 1st next. Every state in the Union should have such a law and that our readers may be familiar with it we reproduce the text in full:

"Section 401 of the New York Penal Code has been amended so as to read as follows:

"Any person, who, in putting up any drug, medicine or food or preparation used in medical practice, or making up any prescription, or filling any order for drugs, medicines, food or preparation puts any untrue label, stamp or other designation of contents upon any box, bottle or other package containing a drug, medicine, food or preparation used in medical practice, or substitutes or dispenses a different article for or in lieu of any article prescribed, ordered or demanded, or puts up a greater or less quantity of any ingredient specified in any such prescription, order or demand than that prescribed, ordered or demanded, or otherwise deviates from the terms of the prescription, order or demand by substituting one drug for another, is guilty of a misdemeanor; provided, however, that, except in the case of physicians' prescriptions, nothing herein contained shall be deemed or construed to prevent or impair or in any manner affect the right of an apothecary, druggist, pharmacist or other person to recommend the purchase of an article other than that ordered, required or demanded, but of a similar nature, or to sell such other article in place or in lieu of an article ordered, required or demanded, with the knowledge and consent of the purchaser. Upon a second conviction for a violation of this section the offender must be sentenced to imprisonment, for a term of not less than ten days nor more than one year, and to payment of a fine of not less than ten dollars nor more than five hundred dollars. The third conviction of a violation of any of the provisions of this section, in addition to rendering the offender liable to the penalty prescribed by law for a misdemeanor, shall forfeit any right which he may possess under the law of this state at the time of such conviction, to engage as proprietor, agent, employee or otherwise, in the business of an apothecary, pharmacist or druggist, or to compound, prepare or dispense prescriptions or orders for drugs, medicines or foods or preparations used in medical practice; and the offender shall be by reason of such conviction disqualified from engaging in any such business as proprietor, agent, employee or otherwise, or compounding, preparing or

dispensing medical prescriptions or orders for drugs, medicines or foods or preparations used in medical practice.

Section 402. This act shall not affect or impair any liability, penalty or punishment under the provisions of section four hundred and one as the same existed prior to the time this act takes effect, but the same may be enforced, prosecuted or inflicted as fully and to the same extent as though this act had not been passed; and all actions civil or criminal instituted under or by virtue of said section as the same existed prior to the passage of this act, and pending immediately prior to the taking effect hereof, may be prosecuted and defended to final effect in the same manner as though this act had not been passed.

"Section 403. This act shall take effect September first, nineteen hundred and seven."

This means much to the medical profession, more than appears at first glance; we all know the druggists on whose honesty we can depend, but we cannot be sure that our prescriptions will go to these, and we have the chance of trying to cure disease with remedies of another's choosing. The profession of New York is indeed fortunate in being thus safeguarded against substitution. In this connection, the profession would never have had this law had it not been for the tireless energy and persistent efforts of Mr. Charles Roome Parmele and Senator Alfred R. Page, who introduced the bill. Mr. Parmele has suffered from the substitutor severely, his reputation and fortune are at stake in arsenauro, and every instance of substitution was a blow. In the face of tremendous opposition, and without the enthusiastic co-operation of the medical profession, which the matter merited, and which its character would lead one to expect, he has piloted the bill to its enactment and, we are told, they enforce laws in New York. Other states are going to watch the effect of this law in New York, and we predict similar enactments in various of the states as a result.

The Southern Medical Association.

UNDER the above title a very vigorous branch of the A. M. A. has been organized which confines its membership to physicians of Alabama, Georgia, Tennessee, Mississippi, Louisiana, Florida and Kentucky. The scientific work of this association is done in three sections. The present president is Dr. Henry H. Martin, of Savannah, Ga., the secretary is Dr. Raymond Wallace, of Chattanooga. The next meeting will be held at Birmingham, Ala., September 24, 25 and 26.

In a peculiar sense this association should interest the St. Louis profession, a considerable proportion of its territory is tributary to us and commercially dependent on us; our schools are filled with their sons who are seeking professional education, we come more nearly to being *of them* than does any other of the large cities of the country. St. Louis should be well represented at the Birmingham meeting, and should lend its aid in every possible way to the promotion of its welfare. And we would urge those of our readers who are residents of the states making membership possible to identify themselves with the association and to attend its meetings.

The Local Campaign Against Charlatanism.

THE Committee on Public Health and Legislation of the St. Louis Medical Society has for the past two years been waging an active and effective warfare against medical fakery. The conduct of the fight necessarily requires funds and the cause should interest all who believe in clean medical practice. A call was made some time since for contributions to a fund to make possible the continuation of the good work and a considerable number of responses with checks have been received, but the fund is still considerably short of the amount needed, and the chairman asks that others lend their co-operation in this practical form. Make checks payable to Dr. Chas. J. Orr, treasurer, send to Dr. H. J. Scherck, chairman, Century Building.

The following physicians have already subscribed to this fund: H. Tuholske, Ernst Jonas, Willard Bartlett, J. D. Menistrina, John McH. Dean, Robert Burns, Nathaniel Allison, Robt. E. Schlueter, Walter B. Dorsett, F. Reder, Louis Rassieur, N. B. Carson, Henry Jacobson, C. H. Shutt, W. M. Robertson, Philip Hoffman, E. Lee Dorsett, Henry L. Wolfner, M. Wiener, T. A. Martin, P. J. Heuer, Frank R. Fry, Frank L. Henderson, Greenfield Sluder, C. Fish, E. E. Kurtzborn, P. Y. Tupper, R. Emmet Kane, E. E. Furney, H.W. Herman, C.W. Tooker, G. O. Gauen, Robt. J. O'Reilly, Joseph H. Scharf, H. S. Crossen, R. W. Baker, M. H. Post, A. Alt, John E. Faber, H P.Wells, C. R. Lightner, W. J. Doyle, H. N. and Selden Spencer, Heine Marks, Anthony O. Young, F. J. Lutz., A. H. Sante, M. R. Horwitz, F. L. Bishop, Wm. H. Grote, Henry Rohlfing, Wm. S. Deutsch, Justin Steer, E. Senseney,

McDowell Botts, Henry Schwartz, L. S. Butler, M. E. Haase, H. McC. Johnson, Edwin Schisler, John C. Morfit, Carl Althans, Buie Garstang, T. R. Ayars, Geo. P. Hemm, John Frohne, Fayette C. Ewing, H. L. Wichmann, Aug. Schwarze, J. J. Russler, B. M. Hypes, C. G. W. Jungk, J. H. Weinsberg, J. Spiegelhalter, E. O. Greer, W. A. Fries, Ed. H. Eyermann, J. J. Jeude, B. E. Stockwell, H. A. Geitz, C. Loeb, H. N. Lyon, S. I. Schwab, Jesse S. Myer, H. J. Scherck, W. E. and Walter Fischel, Robert H. Davis, C. A. Vosburgh, B. A. Wilkes, Frank A. Glasgow, D. R. Parman, H. M. Moore, M. W. Hoge, L. H. Hempleman, W. W. Graves, Robert M. Funkhouser, C. M. Nicholson, W. A. Hardaway, E. W. Saunders, Aaron Levy, L. Caplan, L. C. McAmis, H. S. Mudd, T. A. Hopkins, C. E. Burford, E. C Burnett, F. M. Rumbold, R. F. Miller, D. C. Gamble, Gib W. Carson, H. J. Cummings, Llewellyn Williamson, Frank Ring, H. W. Loeb, N. M. Semple, W. E. Sauer, John Green, Jr., M. G. Seelig, Edw. H. Higbee, M. A. Goldstein, Orville Harry Brown, Wm. Engelbach, M. B. Clopton, G. Baumgarten, Y. H. Bond, Geo. Gelhorn, Elizabeth B. Reed, R. D. Carman, G. H. Haverstick, E. J. Goodwin, Otho F. Ball, W. McCandless, Chas. Wyche, John J. Larew, L. S. Luton, Leon Strauss, Wm. M. Bryan, W. G. Moore, E. E. Rusk, Louis H. Behrens, N. Hampton Nash, J. W. Moore, H. Gyde Lund, Chas. Dixon, Carroll Smith, M. F. Engman, F. H. Albrecht, L. J. Oatman, Jno. M. Grant, R. Hill, John O. Guhman, R. W. Barnes.

THE RETURN OF THE VACATIONISTS.—Though we may expect a continuation of hot weather for some little time, yet the medical men who have been vacating have begun to return and are again getting into harness. We haven't yet heard who caught the biggest fish, or climbed the highest mountain, but we know that it is coming.

THE MEDICAL REVIEW.—The Medical Review as a monthly has made its initial appearance and a very creditable appearance it is. The journal now appears under staff editorial management with Dr. L. H. Warfield as chief. Dr Warfield does not see things just as we do; we would not expect it as his chief view is tuberculosis, and he can see that where we cannot. The attention given the FORTNIGHTLY in Dr. Warfield's first is fully appreciated. Come again. You do not have to agree, this would be a tame world did everybody think in one groove.

MEDICAL PROGRESS

Comprising the Regular Contributions of the Fortnightly Department Staff.

INTERNAL MEDICINE.

O. E. LADEMANN, M. D.

Visible Pulsation of the Brachial Artery in Arteriosclerosis.—Doll (Weiner klinische Rundschau, No. 13, 1907) claims that a visible pulsating brachial artery is quite suggestive of an arteriosclerosis, and when associated with other symptoms renders the diagnosis of arteriosclerosis with a greater degree of certainty. This sign is not manifest with an existing insufficiency of the aortic valves. To render the sign visible the arm must be extended, and the pulsation is best seen on the inner surface in the immediate neighborhood of the elbow-joint.

The Formation and Elimination of Oxalic Acid in Infectious Diseases.—Mayer (Deutsches Archiv für klinische Medizin, Bd. 90, Heft 3 and 4, 1907) noted an increase of oxalic acid in the urine of tuberculosis patients. This increase, when not of alimentary origin, is indicative of pus somewhere in the economy, and is to be regarded as an unfavorable prognostic sign. An increase elimination of oxalic acid in the urine occurs in all prolonged streptococcus and staphylococcus infections, as erysipelas, sepsis, purulent meningitis, while infections, as typhoid fever, diphtheria, measles and scarlet fever, oxalic acid is not increased.

A Diagnostic Sign in Appendicitis.—Tretzel (Muenchner Medizinische Wochenschrift, No. 30, 1907) emphasizes the value of a symptom, first published by Blumberg, although the author claims to have recognized it long ago. The symptom consists of a characteristic pain in the region of the inflamed area upon a sudden withdrawal of the palpating hand. The symptom is not only found in inflammatory conditions of the appendix, but in all conditions causing an irritation of the peritoneum, such as certain forms of gastric ulcer, diseases of the adnexa where the peritoneum is also involved. On the other hand, it is rarely ever present in other abdominal affections, such as catarrhal conditions of the bowel, colic, ileus, distension, etc. The symptom, however, loses its value in chronic cases of appendicitis where there are adhesions, in the presence of an exudate resulting from a perforation.

Severe Hemoptysis Treated by Means of Ice Bags.—Downes (British Med. Jour., June 29, 1907) details the case of a man, 28 years old, with severe hemoptysis which re-

sisted such methods as the administration of amyl nitrite in doses of three minim capsules at short intervals, hypodermic injections of one-quarter grain of morphia, absolute rest with shoulders slightly raised, a milk and egg diet, and mild saline aperients. Finally an ice bag was applied over the front of the right upper lobe where it was continuously kept night and day, the ice being frequently changed, for a period of six days, all other drugs being discontinued. Not a single drop of blood was expectorated from the time of its first applications. The patient rapidly improved in health, gaining fifteen pounds in twelve weeks, and free from any cough or expectoration. The author remarks that it is seldom that the bleeding point can be localized with sufficient accuracy for the ice to be applied directly over the seat of the hemorrhage, and thus to produce reflex contraction of the pulmonary vessels in the affected lobule. If applied in the wrong place, it probably does harm by raising the blood pressure in the region of the hemorrhage.

A New Indicator for Free Mineral Acids.—Adler (Jour. Am. Med. Ass., August 3, 1907) says that while Günzburg's test is very delicate, it has the disadvantage that the reagent rapidly deteriorates, which tends to render its use unreliable. He proposes as substitute and fully as sensitive a colorless fluid, discovered by Emerson, to which the name of carminogen has been given. This fluid in the presence of free mineral acids, will give on drying, a carmine color. The solution is practically permanent, if kept in a stoppered bottle. If exposed to the air any length of time it may turn slightly brown, but this will in no way impair its efficacy. The method of application is the same as with the phloroglucin-vanillin test. A point to be borne in mind is that the color does not appear until all moisture has been driven off. The indicator may be even more conveniently used, especially for office practice in the form of test papers. These are prepared by saturating filter paper with the colorless solution and drying in the air. The paper is fully as delicate as the solution. The best method of using it is to moisten the paper with a drop of the stomach contents, and then to dry the same thoroughly by gentle heat, preferably in a small evaporating dish over a Bunsen flame.

A Pathognomonic Eye Symptom in Rabies.—Coakley (N. Y. Med. Jour., July 16, 1907) noted a peculiar pinpoint contraction of the pupil of the left eye in a rabid fox terrier. After applying atropine at intervals of ten minutes for one hour, he failed to influence the contraction. The pupil was also unresponsive to cocaine and light. Large hypodermic injections of cocaine and atropine were also negative. The same phenomenon was noted in subsequent observations with such constancy as to lead the author to believe it pathognomonic of rabies. It must not be confounded with papillary contraction, which sometimes follow the sudden removal of an animal from a dark cage to a bright light. If there is any doubt as to the permanency of the contraction, mydriatics should at once be used; if mydriasis is secured and the animal lives for several hours, we may be sure we are not dealing with rabies.

Opsonins, Opsonic Index and Vaccine Therapy.—Hollister (Med. Rec., July 20, 1907) read an interesting paper on this subject at the 57th annual session of the Illinois State Medical Society. He says that to aid a patient in his struggle against infection we should strengthen his phagocytic power. If this phagocytic power depended on white cells and opsonins, we must have a method of determining what was the condition of such factors, and, if they were insufficient, we must be able to cause an increase in their number. We could increase the number of leucocytes, but we know that this was not the same as increasing phagocytosis. Wright had not only perfected a method of determining the strength of the opsonic power, but also of increasing it if it was low; the first by what was known as opsonic index, the latter by vaccine therapy, and by Wright's methods we could not only estimate the patient's phagocytic resisting power to individual infections, but we could help him to get well by raising that power. We must aid phagocytosis in order to strengthen resistance. Phagocytosis had two factors, leucocytosis and opsonins. We could increase the number of leucocytes, but that was of limited value. We could estimate the opsonic strength of the infected patient, and we could be of marked assistance if we were able to raise and maintain his opsonic index. The presence of invading bacteria stimulated further elaborations of opsonins in the serum. This was not only so if live pathogenic germs gained access, but it had been found to be true if one took the same germs and sterilized them by heating, thus destroying their pathogenic power, and then injecting them into the tissues of the body. This was what was meant by vaccine therapy. We injected into a patient whose opsonic, and therefore phagocytic, power was low a sterilized culture of the very germ that was causing his individual disease, and when this was done, by a definite, careful

method, it was found that his opsonic index could be raised, and that when so raised his tendency was towards recovery. In what infections could we say vaccine therapy was of definite value? First, in staphylococcus infections; acne furunculosis, carbuncles, and the more generalized forms of staphylococcus invasion. Second, in infections by the colon bacillus; pyelitis, cystitis, pleuritis. Third, infections by the tubercle bacillus, especially in localized tuberculosis of the skin, bones, joints, and genito-urinary tract. The author had not yet had sufficient experience in the treatment of pulmonary tuberculosis to draw conclusions. Fourth, as to infections by the gonococcus. Here he could say, judging from about twenty cases, that a person infected by that organism, acutely or chronically, usually had a low index, and that this low index could invariably be raised and maintained at a higher level. After a sufficient number of cases had been tested by the gonoccocus vaccine without other measures, he thought we would be able to estimate the actual results. The outlook was promising in spite of the fact that the technique was difficult.

OTOLOGY.

ALBERT F. KOETTER, M. D.

Spontaneous Operation in Cholesteatoma.—(Sune-Medan., Barcelona.) — Woman of twenty-eight; two months ago pain in ear, pulsation, vertigo, one month ago swelling over mastoid and slight secretion. On examination considerable drooping of posterior superior wall of canal so that only the lower portion of membrane is visible. Behind the ear fluctuating swelling. After incision evacuation of large amount of fetid pus, the knife enters large cavity without resistance. On the following day in changing dressing large mass of cholesteatoma discharged. The whole cavity can now be inspected and shows absence of posterior wall of canal, as after radical operation, slight facial paralysis, four days later cavity entirely dry, after eight days complete epidermization, and after one and a half months complete closure. The remarkable feature of this case is the rapid disintegration of the posterior canal wall in course of a month, as well as the immigration of the cholesteatoma to the squama between the bone and periost. At present the patient is well, the membrane is closed, hearing distance one-half of the normal, no tinnitis, no vertigo, facial normal.

A Case of Acute Sepsis in Middle Ear Suppuration.—(John Dunn-Richmond, Archives of Otology).—Boy of 16, three days after severe pain in left ear, chill in early morning with high temperature. Remission in the afternoon, renewed rise in the evening. Similar temperature curve the next few days. No discharge from ears, no swelling over mastoid or over the jugular. Fundus of eye normal. Paracentesis evacuates blood. Antrum full of pus, the sinus was opened and found healthy. Continuance of high temperature. Two days after pain in right breast and consolidation in right upper lobe. Rapid recovery. From the fact that the pus was limited to the antrum and one of the neighboring cells, that no granulations were found in the antrum, that the bone was healthy the author believes that the infectious material was taken up by the blood vessels.

The Favorable Influence of the Internal Use of Potassium Iodide in Tuberculosis of the Upper Air Passages.—(Gruenberg, Zeitschrift fuer Ohrenheilkunde.)—On the basis of accidental observations, patients in Koerner's clinic having tubercular disease of the upper air passages are given besides the customary local therapy (cauterization with lactic acid) long continued administration of potassium iodide (2g. daily). Favorable results were obtained in a great many cases, but because of the fact that tuberculous disease may heal spontaneusly, the favorable action is not ascribed to the potassium iodide, but to the valuable aid in the healing process by this medication. Although the favorable influence on tubercular processes by means of potassium iodide, a successful treatment in difficult differential diagnostic cases, a diagnosis of lues cannot be made. The combination of external (local) and internal (potassium iodide) treatment is especially applicable in patients with primary ascending mucous membrane tuberculosis, for patients, whose general condition has not been materially reduced, whose lungs are healthy or only slightly involved. In extensive infiltration and ulceration of larynx tuberculosis the iodide therapy is not indicated, rather in circumscribed tumor formation. Of six cases published, in all of which tuberculosis was diagnosed microscopically, case 3 is of unusual interest. A boy of 13, with tuberculosis of the pharyngeal tonsil and tubercular papillomatous tumors in the larynx, a tumor under the anterior commissure of the vocal chords disappeared entirely under this treatment, which could not be removed by means of instruments.

Rare Termination of Otitis Externa Circumscripta.— Krebs (Therapeutische Monatshefte) reports complications in three cases

of circumscribed external otitis caused by rupture of suppuration through the wall of external canal: 1. Location of furuncle on the posterior wall, median portion of external canal, a breaking through of the cellulitis may involve the osseous portion of the canal, a periostitis, following this an ostitis as well as empyema and caries of the neighboring anterior mastoid cells, causing formation of cholesteatomatous masses. 2. Location of the cellular inflammation in the cartilaginous portion, on the posterior superior or inferior wall favors a rupture, besides the appearance of the ordinary symptoms (pain on pressure, protrusion of auricle, disappearance of line of insertion, redness and swelling of surrounding tissue) appearance of a subperiosteal abscess behind the ear which can be differentiated from lymph gland abscess because it is formed above the periosteum. 3. A very rare complication of such a subperiosteal abcsess is a continuation of the disease to the planum mastoidium, causing caries and empyema of the mastoid cells. Author healed such a case by operation, a furuncle leading to periostitis on the mastoid process this causing a superficial caries and empyema of the external cells. The statement the author makes of the histological connection between furuncles of the external canal and osseous changes in the mastoid process will meet with not unjustified contradiction.

Enuresis in Children.—(A. Cavalieri, Rivista di Clinica Pediatrica.)—After a short description of the anatomy and physiology of the bladder author differentiates between four kinds of enuresis: 1. Extreme irritation of detrusor muscle; 2, insufficiency of muscle tone of the urethral sphincter; 3, different reflex causes, 4, insufficient development of the prostate. The enuresis of adenoid vegetation belongs to the third group.

Pathology and Prophylaxis of Secondary Parotitis.—R. T. A. Bucknall (The Lancet) mentions the theories of Hanau and Pilliet, they believe the infection takes place from the mouth through Steno's duct and Bucknall reports twelve cases of his own and two hundred from the literature. The secondary parotitis must be differentiated from the primary. As in other acute disease it may be complicated by fever, pneumonia and peritonitis. As to its origin there are different theories: 1. Pyemia or emboli. 2. Degenerative origin. 3. Toxic origin. 4. Sympathetic theories of Stephen Paget. 5. Infection from the duct. The latter theory rests on the microscopical examination, which demonstrated the presence of micro-organisms in the duct, and further proved that the inflammatory process begins in the neighborhood of the excretory ducts in the center of the lobule and spreads to the periphery, most frequently the staphylococcus, then the pneumococcus, pneumo bacillus, typhus bacillus, bacterium coli and streptococcus. Author elucidates his explanation by reports of bacteriological and microscopical examination of his six cases. A great many micro-organism were found at the orifice of the duct, decrease in the quantity of the secretion and reduction in the bactericidal action of the saliva. Antiseptic gargles prophylactically, the treatment consists in cleaning the mouth, immediate incision if formation of abscesses. Finally the author mentions similar affections of the submaxillary, sub-lingual and pancreas.

A Case of Hysterical Pain Over the Mastoid.—(H.G. Langworth, Dubuque, Archives of Otology.)—Patient, girl of fourteen, poorly nourished and undeveloped, otoscopic and functional examination normal with the exception of pain and swelling over right mastoid process, slight nystagmus, slight spasm of sterno-cleido-mastoid muscle. No hysterical stigmata. Treatment by suggestion lead to recovery in a month.

THERAPEUTICS.

A. C. F. BROWN, M. D.

Calomel in Enteric Fever.—C.B. Ker (Edin. Med. Jour., 1906, No. 1, p. 29) after discussing the various antiseptics in typhoid fever, lauds calomel as being par excellence, the best, when used with intestinal irrigations. He calls his treatment "antisepsis by elimination," and has used it in over 700 cases of enteric fever. The treatment consists in giving aperient doses of calomel (three grains) every second or third day supplemented by hot water irrigations of the colon. Milk is the main diet and copious libations of water. He claims the advantages of this method are that it produces no pain, and does not cause diarrhea. His percentage of perforations was under 2 per cent; hemorrhage occurred in 8 per cent. Marked meteorism is a contraindication to the use of calomel, but this may be caused to disappear and calomel allowed after twenty-four hours, unless blood appears as the result of the enema. Mercurialism was never noticed. He makes the claim that the treatment leaves the patient free to deal with the enteric poison, and relieves him from septic absorption; bowels are kept clean, meteorism is reduced and diuresis is assisted.

Prevention of Hemorrhoids. — Mathews states that the best agent for the preventive

and palliative treatment of internal hemorrhoids is cold water. Do not allow the patients to inject hot water into the rectum; it causes a distention of the veins and further protrusion of the hemorrhoids. Cold contracts, therefore, if your patient will drink a mineral water to keep the bowels open, and will apply cold water to the mass after the bowels move, and will inject moderately cold water into the rectum to aid every movement, he will get good results. If an ointment is desirable the following may be used:

℞ Hydrarg. chlor. mitis..... gr. xl
Morph. sulph..... gr. vj
Cocainae muriatis ..... gr. xij
Vaselini ..... ℥j

M. Ft. unguentum. Sig. apply night and morning.

Treatment of Urethritis.—Guiteras explains the methods by which he has obtained the best results in the treatment of urethritis. He treats the acute stage with alkalies, and the anterior astringent injections, composed of five grains each of sulphate of zinc, alum, and carbolic acid, with one drachm of glycerine to the ounce of distilled water; this is used three times a day after washing out the anterior urethra with hot water. Where there is great inflammation about the glans and prepuce, with possible lymphatic complications he vomits the injections and employs diluents, hot baths and purgations. If the above injection has no effect he employs a stronger one, composed of ten grains of sulphate of zinc and half ounce of fluid extract of hydrastis to four ounces of water. Should this fail, he employs a still stronger one, composed of ten grains of the sulphate of zinc, fifteen grains of acetate of lead, one drachm of each of tincture catechu and tincture of opium to four ounces of water. This treatment is, as a rule, sufficient; but should the posterior urethra become involved, low diet, tincture of belladonna are given; as soon as the symptoms abate somewhat instillations of nitrate of silver, one grain to the ounce are given, and at the same time sandalwood, cubebs, or copaiba by the mouth. If the discharge is rebellious, daily irrigations of a solution of permanganate of potash are employed, the catheter being passed as the bulb of the urethra, or, if necessary, the fluid may be injected into the bladder. If the gleety discharge continues, an endoscopic examination should be made and nitrate of silver applications made through it.

Treatment of Hay Fever.—Dr. J. Robertson (Med. Council) states there are four facts dependent on their relation to each other as a basis for theory and treatment of hay fever: 1. There is a constitutional idiosyncrasy. 2. There is an exciting cause. 3. These two acting in conjunction produce the disease. 4. If either the constitutional idiosyncrasy or the exciting cause can be corrected the disease will be mastered. To remove the exciting cause he dwells upon the inefficiency of the spray and its method of application, as it can only reach the larger and more direct passages, while the inflammatory process extends to tracts of the Schneiderian membrane, which cannot be reached by the spray. He therefore strongly recommends the nebulizer as a means of reaching these out of the way places, such as the firmer air passages, the sphenoidal and ethmoidal sinuses, the antrum of Highmore and other cavities lined by the Schneiderian membrane. However, he states, it is better, as a first step in the treatment, to spray the nose and throat out with one of the following:

℞ Zinci sulphatis..... gr. x
Aqua destil..... ℥iv

M. Sig.: Use as a spray in the ordinary cases having a watery discharge.

Where the discharge is profuse, with pain and tenderness, use the following:

℞ Morphinae sulph..... gr. ij
Atropinae sulph..... gr. iss
Zinci sulph..... gr. xvj
Aqua camphorae q.s.ad..... ℥iv

M. Sig.: Use as a spray locally. After using the spray, apply the following in the form of a vapor in the nebulizer to reduce the turgescence and to give temporary relief:

℞ Cocainae, pure alk ..... gr. viij
Menthol.....
Camphorae .....aa gr. xx
Ol. carophylli..... *m* xij
Liq. albolene..... ℥ij

M. Sig.: Use in the form of a nebula.

It is evident that constitutional disturbances as well as hereditary dispositions enter into the etiology of hay fever. The sufferers from hay fever are usually neurotic, anemic and poorly nourished. The gastro-intestinal tract and the general elimination should receive due attention in the treatment of patients from this disease.

Dysmenorrhea.—

℞ Pulv opii..... gr. j
Sacch. albi..... ℥j
Ol. menth. pip..... gtts. ij

M. ft. chart No. vi. Sig.: One powder every two to four hours.

℞ Tinct. opii ..... *m* xxx
Inf. anthelmidis..... ℥iv
Aqua menth. pip.....
Syr. simplicis .....aa ℥ss

M. Sig.: One to two tablespoonfuls every two hours.

Epileptic Attacks Following Suppression of Menses.—

℞ Ext. mucis vomicae ..... gr. x
Pil. aloes et myrrh..... ʒij
M. Divide in pil. No. xxxvi. Sig.: One or two twice daily.

Erysipelas.—

℞ Tinct. ferri chloridi.....
Tinct. cinchonae.....aa ʒij
Quininae sulphatis..... gr. xxx
Aqua..... ʒiss
M. Sig.: Apply with a brush three times times daily over affected area.

Menorrhagia.—

℞ Ferri chloridi..... gr. xvj
Tinct. opii ..... gtts. x
Syr. toluanti..... ʒij
Aqua..... ʒvj
M. Sig.: Tablespoonful every one to two hours.

℞ Acidi gallici..... gr. xv
Acidi sulphurici aromat..... *m* xv
Tinct. cinnamoni..... ʒij
Aqua destil..... ʒss
M. Sig.: Tablespoonful in water every four hours.

Mumps.—

℞ Ichthyol.....
Plumbi iodidi.....aa gr. xl
Ammon. chloridi..... gr. xxx
Adeps..... ʒj
M. Sig.: Apply to swollen parts t.i.d. Lanolin may be used in place of lard and belladonna may be added.

Treatment of Whooping Cough. — Kilmer of New York (Archives of Pediatrics, Vol. XXIV, No. 2) describes his method of treating this disease in children by means of an improved abdominal belt made by linen with a strip of elastic webbing two inches wide inserted on either side, which is sufficient to give elasticity, the belt laces in the back, by means of which any degree of constriction can be maintained. It can be worn over the undershirt, different widths are used according to the age of the child for infants four to five inches wide, for children from 5 to 8 inches wide. The length of the belt should be such that when complete it should measure three inches less than the circumference of the abdomen at the navel. The degree of constriction should be determined in each case. A slight degree is sufficient to produce a moderation of the cough and cessation of vomiting. Should symptoms not abate after the belt is applied, it should be tightened slightly. Usually a sense of comfort is expressed by the children who are old enough to make themselves understood.

CORRESPONDENCE

AN APPEAL TO THE AMERICAN PROFESSION.

On May 8th, the day following the meeting of the National Association for the Study and Prevention of Tuberculosis there appeared in the North American of Philadelphia a most sensational article by Mr. Richard J. Beamish, according to which, during the discussion of Dr. Flick's report on medication, I was reported to have advised the killing of dying consumptives quickly and painlessly by heavy doses of morphine, and to have admitted that it was my practice to do so. It was furthermore said in this article that there had been a bitter debate, and that the session adjourned in confusion. These false statements were copied by nearly all the newspapers in the United States, were cabled to Europe and made the rounds in the papers and magazines of England and the whole European continent. In spite of explanations and denials I had sent to the Associated Press, in spite of a strong letter written by Dr. George Dock, the presiding officer of the meeting, and sent to the leading medical journals of America, giving the true version of my remarks, the false statement has continued to be published and republished and commented upon to the great detriment of the anti-tuberculosis crusade all over the world. For example, ignorant consumptives in St. Louis, who had read the sensational lie, refused the visit of the nurses sent to them by the society for the Relief and Prevention of Tuberculosis. The St. Louis Republic, which published this news item, said, "Consumptives since they read that report apparently have a dread that the visit of the nurse may mean morphine to end their suffering." It became thus necessary to issue the following statement by order of Prof. Frank Billings, president of the National Association for the Study and Prevention of Tuberculosis:

Various daily newspapers published on May 8th, what purported to be a report of the remarks of Dr. S. A. Knopf, of New York, before the National Association for the Study and Prevention of Tuberculosis, in which he was made to say: "It is my practice and your sacred duty when you see a dying consumptive before you to give the sufferer morphine in plenty that the end may come quickly and painlessly."

No such statement was made by Dr. Knopf, but since in spite of an immediate explicit denial by the doctor a great many newspapers in this country and Europe continue to pub-

lish the false report as authentic news, Dr. Frank Billings, of Chicago, President of the National Association for the Study and Prevention of Tuberculosis, authorizes the following statement:

"Quite apart from the false position in which the speaker was placed and the injury done him, the publication of such a piece of sensationalism cannot fail to have a very deleterious effect upon impressionable tuberculous patients throughout the country, and may keep others from seeking needed medical aid."

The following statement made by Prof. George Dock, of the University of Michigan, who presided at the meeting at which Dr. Knopf spoke, should preclude all further misunderstanding:

"I heard clearly what Dr. Knopf said. I am sure that I know what he meant, and sure that everybody in the room must have understood what he said. His words could not possibly be converted into the meaning given in the public press. It was perfectly clear that he meant to relieve patients in the last stages. Everybody knows that this prolongs life, while making it very much easier for the patient." LIVINGSTON FARRAND,
Executive Secretary.

I had hoped that this statement would put a stop to all further comments on and circulation of the sensational falsehood. I am free to confess that I have longed for the time when the lie would die out, for in spite of the loyalty manifested by my professional friends during these hours of trial, for which I beg them to accept my most heartfelt thanks, the ordeal had become almost unbearable.

It seems that such a lie dies hard and from time to time receives a new stimulus from the over-zealousness of some physician or layman. Thus, for example, through the courtesy of Dr. George H. Simmons, the editor of the Journal of the American Medical Association, I received a copy of the Kansas City Journal of last week, containing an editorial under the heading, "Should Doctor's Kill," from which I quote the following:

"The question whether a physician is justifiable in shortening the life of a patient suffering from an incurable disease by administering anesthetics was given a fresh impetus recently by the declaration of Dr. S. A. Knopf before the tuberculosis congress in Washington advising that consumptives should be given heavy doses of morphine to hasten the end. To the credit of the profession it must be said that physicians generally repudiate the idea as atrocious and a violation of medical ethics. A Chicago physician, Dr. Charles Gilbert Davis, voiced this sentiment, saying: 'A physician who would make a statement of that sort should be taken out and hanged.' The profession has not gotten so low that it must commit murder just because it has not yet discovered a cure for some disease. There is nothing incurable under the sun. Just because the cure has not been discovered that does not mean that it never will."

In Dr. Dock's letter above referred to, as well as in the statement authorized by Dr. Billings, the absolute falsehood of the respective newspaper report was clearly shown, and it would seem that there was hardly an occasion for Dr. Davis to unburden his feelings for the benefit of the lay press.

Equally untrue was the report of the alleged "adjournment in confusion" and the lively and bitter debate" which followed Dr. Flick's report, condemning the use of morphine and its compound. In refutation of this reflection made by Mr. Beamish on a body of scientific men composed of many of the leading American physicians, who have devoted their lives to the study and prevention of tuberculosis, permit me to publish for the first time an extract from a letter which was received recently by Dr. Joseph Walsh, the secretary of the section:

"I was present as secretary of the section at which you spoke, and instead of the section breaking up in confusion as was stated in the newspapers, the section closed in the perfectly regular way, and your statement as generally understood by the medical men seemed to be generally agreed with."

I beg the medical press of the United States to copy this communication in the hope that it will help individual members of the profession to refute once for all the inconceivable proposition that any physician true to his calling could possibly propound such a doctrine as shortening the life of any patient entrusted into his care. To the individual members of the profession in this country and abroad I address a personal appeal to embrace every opportunity to disabuse any individual who may labor under the misapprehension that I or anybody else of the American medical profession recommended shortening the lives of consumptives or any others by the administration of chloroform, morphine or similar narcotics. I make this appeal not merely for my own sake, but above all, for the sake of truth, and for the sake of consumptive sufferers in this and in other countries.

S. A. KNOPF, M. D.

New York.

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MEDICAL MISCELLANY

RECENTLY seventy-eight bacteriologic examinations of dirt removed from beneath finger nails were made in Vienna. The result was that thirty-six kinds of micrococci, eighteen bacilli, three sarcines and spores of common molds were found. These findings emphasize the necessity of thoroughly cleansing and disinfecting the nails in surgical, obstetric, and other procedures through which infection may be conveyed.

SALE OF DRUGS IN TURKEY.—The Constantinople correspondent of the Lancet states that several fatalities are reported as the result of selling drugs to the public without a prescription. A law exists in the Ottoman Empire prohibiting this, but like many other good laws in Turkey it remains a dead letter for lack of strong will and hand to compel its enforcement. All kinds of drugs, even the most poisonous, have been sold by all kinds of shops to any one on demand. The abuse has been especially great with regard to proprietary articles, the composition of which is unknown. The law entrusts the whole matter to the prefecture of the city, and this, in turn, has to see that every medicine and pharmaceutical preparation is sold to the public only by authorized duly qualified pharmacists and officially recognized specialists, and only then when the properly signed prescription of a medical man is presented. Recently a new official communication has been sent to all the pharmacists and druggists in Constantinople reminding them of the law and calling attention to the penalties that will follow further indiscriminate sale of drugs.

PASSENGERS arriving in New York from Cuba now have their temperatures taken at quarantine, and if thought advisable are kept under observation for a day or two at Hoffman Island. An arrangement has been made in Havana, under the sanction of the United States Marine Hospital Service, to enable passengers to the Southern States to avoid detention on landing by spending several days under observation in a quarantine camp before sailing. It is planned to centralize the sanitation of the whole island under Major Kean, United States sanitary supervisor.

CHLORAL HYDRATE IN SCARLET FEVER.—Dr. Royer, in Therapeutic Gazette, details his experiences with chloral hydrate in the treatment of scarlet fever. He studied 800 cases which were treated with routine doses of that drug, given in quantities large enough to produce light somnolence. A series of 796 patients who were treated by the usual remedies was analyzed in the same way. The patients in each series were parallel cases as near as it was possible to select them. Three patients died in the chloral series, and four in the usual remedy group. From his experiences, which were detailed in full, the following conclusions were drawn: First, chloral hydrate is of distinct value in the treatment of scarlet fever, and when used in doses of sufficient size to secure light somnolence, does not seem to be a circulatory depressant. Second, chloral hydrate ameliorates nervous symptoms better than any remedy yet suggested in the treatment of scarlatina. Third, chloral hydrate allays the itching of the skin often found annoying in scarlet fever. Fourth, when chloral hydrate is given routinely during the febrile period, and for some days thereafter, postfebrile nephritis appears to be less frequent. Fifth, this study would seem to justify the more extended use of chloral in the treatment of scarlet fever, and a more detailed study as to how it acts on the kidney itself.

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ANNOUNCEMENT

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Please mention this Journal.

The Treatment of Inoperable Malignant Tumors—Carcinoma.—(J. M. G. Carter, M. D., Sc.D., Ph.D., Waukegan.)* I have two reasons for presenting a discussion of the treatment of cancer at this time: First, the importance of the subject, and, second, the hope that I have discovered a method which may result in saving many lives. It has been affirmed by Wutzdorff that there has been an increase in the number of cases of cancer in the last few years, and some, with Sir W. M. Banks, believe the increase is due to excessive meat eating. At any rate, it has been shown that many cases occur in robust and well fed individuals and especially in the comparatively young of both sexes. It often happens that the presence of such a growth is not suspected until it is too late for operative interference, because of the fact that the appearance of the patient does not indicate the progress of the disease (Nothnagel). Many cases also occur which cannot be operated on because of the location, as when situated near vital organs or around important blood vessels. Then, again, there are patients who will not submit to an operation.

Lauder Brunton was the first to investigate the chemical composition of cell-nuclei from which has been secured a compound called nuclein. This substance is an albuminoid and contains phosphorus. Nuclein is the most distinctive element of leucocytes, being the constituent by virtue of which the cell grows (F. R. Larned). Vaughn and McClintock have demonstrated that the nuclein is the germicidal agent in blood plasma and is furnished by the polynuclear leucocytes.

The bromide of gold and arsenic is another remedy which, in my hands, has seemed to prove useful in the treatment of inoperable carcinoma; but I have always used it in connection with other agents. I have had more confidence in the nuclein than in the bromide, chiefly, perhaps, because I have had two cures in which I did not use the bromide, while I have had none where nuclein was not used. I have come to consider the administration of nuclein and the bromide of gold and arsenic together as a most rational and valuable treatment in cases of inoperable carcinoma. It is the combination upon which I depend rather than on either agent singly.

I have used this method of treatment in many cases with apparent benefit, but I am able to report only five cases in which the treatment was carried out as prescribed from the time the patient came under my observation until the termination of the case. One of the cases died. The other four recovered.

CASE I.—Mrs. S., aged 50. She had suffered no serious illness prior to the beginning of her present ailment, about one year before my first visit. Her first symptoms were indigestion, flatulence, heartburn, eructation of gas and similar disturbances of the stomach. The symptoms had gradually grown worse until pain and vomiting had supervened some weeks before. She had lost flesh and grown weak. At the time of my first visit, the patient was lying on a couch, in pain, pale and cachectic. She had been vomiting and apparently had suffered much. The ejecta having been destroyed, no opportunity offered to analyze the vomited material at that time. The temperature was normal. Temporizing treatment was adopted and the patient was not seen again for a week. Then I was summoned hastily to see her and found her vomiting and in great pain. She had not been free from these symptoms since my former visit. This time, following my directions, the vomited material had been reserved for examination. The patient had not improved. The ejecta were typical and abundant and contained dark grumous material, mucus and remnants of food. The occurrences of vomiting were periodical. A distinct tumor could be outlined at or near the pylorus. The bowel evacuations also contained a dark material. Chemical examination showed increase of lactic and absence of hydrochloric acid. The microscope showed cell-nests and bacteria. Diagnosis, carcinoma of the stomach.

Treatment.—The local treatment consisted of the use, by mouth, of a 2 per cent solution of hydrozone. The patient was told to drink half a pint of this solution half an hour before meal-time, lie on the back for five minutes, then turn on the right side and remain in that position for 25 min-

*Abstract of paper read before the Section on Medicine of the Illinois State Medical Society at Springfield, May 15-17, 1906. Ill. Med. Jour., January, 1907.

utes. This remedy was given for its antiseptic effect. The internal treatment was nuclein. The particular preparation was Reed & Carnrick's protonuclein. The dose was 24 grains a day. This time the patient was kept under observation for a month, until the symptoms were not quite so severe. The treatment was continued, however, and after several weeks I called to see the patient in another exacerbation of her symptoms; but this time they were not so severe. After a few days I dismissed her again, with advice to continue the nuclein, but to omit the hydrozone. Some five months later I called to see the patient and found her at work about the house. The symptoms and tumor had disappeared and the cachectic look had given place to a more healthful appearance. I did not see her again, but three years later I was informed that she was well and had no return of the old symptoms.

CASE V.—Mr. M. L. E., aged 55, a teamster. He had been strong and well and usually free from any ailment except a diarrhea until about a year before I saw him. The first intimation he had of serious trouble was in March, 1904. At that time he had pain and diarrhea. A physician was called and discovered a tumor in the region of the sigmoid flexure. After recovery from the temporary illness, he sought advice concerning the tumor; and, although he visited several surgeons of note, no one seemed willing to remove the growth, and their opinions gave him no hope of final recovery and little expectation of temporary relief. Most of them refused to operate, saying that the tumor was probably cancer and he would be better off without an operation.

He came to me in January, 1905, and I found the following conditions and symptoms: He was cachectic, was losing flesh and had a tumor in the region of the sigmoid about the size of a child's head, which was tender on pressure. He had sharp, cutting pains in the tumor, suffered from flatulence, and had a diarrhea with scybalous feces. He came to me because of my success with case II, of which he had heard. I advised an operation. He was willing to submit to one, but said that no one whom he had visited would agree to do it except Dr. J. B. Murphy, who was willing to operate upon request, but could not advise it with any hope of success. He returned to Dr. Murphy and was operated upon about January 25th at Mercy Hospital. Upon opening the abdomen a tumor four or five inches in diameter was found at the sigmoid flexure. The infiltration into the adjacent structures and the adhesions were so extensive that removal was out of the question. The diagnosis was carcinoma of the sigmoid. The wound was closed and the patient returned to bed. About the 20th of February he came to me again, and on February 22, 1905, I began medical treatment. I advised him to return to bed, which he did, and remained in bed for eight weeks after the treatment was commenced. The treatment was bromide of gold and arsenic, 45 drops, and nuclein, 36 grains, daily. By the 1st of May, his pain had ceased, the tenderness had diminished and the tumor had ceased to grow. By the 1st of July, it was plain that the tumor was slightly smaller. He was permitted to return home on September 1st. About the middle of October he came again to my office. The tumor had entirely disappeared and all symptoms had subsided, including the diarrhea. Dr. Murphy saw the patient soon after and confirmed my statement that the tumor had disappeared. A letter from the patient last month states that there has been no return of any of the symptoms—seven months after he was pronounced cured. He is in better health than for many years. January, 1907, one and a half years after the cure was completed, he is in splendid health.

In presenting the foregoing cases, the author does not suggest that he has found an infallible cure for cancer, but rather that such results must convince us that cancer may be placed on the list of curable diseases. The treatment, to be successful, requires great care in carrying out the method. If the remedies are carelessly administered, satisfactory results cannot be expected. In all serious cases and internal tumors, I advise remaining in bed for weeks, depending upon conditions in individual instances. The bromide (i. e., the arsenauro) must be gradually increased. Few patients will bear large doses from the beginning.

MEDICAL MEMORANDA.

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Pain.—This is the condition we are most often called upon in a hurry to relieve. Our therapeutic measures employed will be guaged by the cause, location, severity, etc. A hot water bag should always be accessible. Hypodermic of morphine should be used as sparingly as possible. Papine is an excellent pain-reliever that is devoid of the danger and unpleasantness of ordinary opiates. It relieves pain promptly, but does not produce narcosis, constipation, etc.—W. T. Marrs, M. D., in the Medical Herald.

Lactopeptine, which for many years has filed a demand on the part of the medical profession for an efficient digestive agent, still holds the confidence of those who prescribe it, and, better still, comforts and cures the patient. Lactopeptine is without doubt the ideal preparation for correcting the errors of diet. It may not fulfill the theoretical requirements of the "test-tube" chemist, but all we ask of any doctor is a fair trial in a series of obstinate cases; samples will be furnished free for this purpose. NEW YORK PHARMACAL ASSOCIATION.

General Anesthesia by the Hypodermic Method.—The rapidity with which the Abbott-Lanphear method of anesthesia has advanced in the confidence of the profession is unparalleled. The method is simple, easily used, requires less assistants in surgical operations, is acceptable to the patient, is remarkably free from danger; is devoid of after-effects to a greater extent than inhalant anesthesia, is recovered from promptly and can be adjusted to nearly all patients. Its most marked influence is in the slowing of the respiration, which is apt to alarm those who have not proven that no harm results, the respiration being that of deep sleep. The use of hyoscine instead of scopolamine is a great improvement on the original method, and the introduction of this substance, by Dr. Abbott, and of cactus in the form of cactin in the compound, hyoscine, morphine and cactin comp. (H. M. C. Abbott) has added a safeguard which is invaluable, and which in time will be fully appreciated. Abbott has the confidence of the profession because he makes good. On his presentation it was promptly tried and another success is scored.

The Use of Adrenalin During Ether Anesthesia.—(By Charles S. Venable, M. D., Charlottsville, Va., Virginia Medical Semi-Monthly, February 22, 1907.)—Recognizing that my experience in the use of adrenalin during ether anesthesia is but very limited, covering a course of only eighteen cases, and knowing the many fallacies attendant upon too early conclusions, I feel a great hesitancy in making this report. However owing to the uniform result that has attended its use, I am prompted to do so now. I found that 25 per cent aqueous solution of the standard 1 in 1000 gave the best results, and that by first pouring ether in the towel cone and spraying the adrenalin solution on it, depending on the ether to vaporize it sufficiently for inhalation, was the best mode of administration. Three to six minute intervals are sufficient for its use and a total of from one-half to one ounce of this solution is enough for an operation lasting from thirty minutes to an hour. The effects are a more uniform etheterization, the pulse becoming steadier, slower and of better character more rapidly than under ether alone ; respirations are quiet and regular, the bronchial secretions are practically checked, and the progress of the operation is not interrupted. These cases were not selected, and among them were old alcoholics ; two women over sixty years of age, one of them nearly eighty years of age. Three were very long tedious operations, lasting over two hours, and in none of the series was any stimulation required during the anesthesia. Recovery from the anesthetic was uniformly good ; there was practically no post-operative shock, and no stimulation was needed in any one of the cases ; only two patients vomited at all and very little nausea was complained of. From the foregoing facts I conclude that owing to the contraction of the smaller vessels the bronchial glands secrete less mucus, and there is better aeration in the bronchioles and pulmonary vesicles, less ether is required to produce anesthesia and there is less probability of ether pneumonia following. The adrenalin, acting generally from absorption, is a powerful stimulant ; it materially lessens shock, lessens the capillary ooze at the field of operation, and is of great benefit to the much weakened patient.